

# Knowledge and Use of The 'Clinical Framework For the Delivery of Health Services' in Western Australia

Summary report of a survey of  
Workers' Compensation  
stakeholders



Curtin University

## Dr Tim Mitchell, PhD

Senior Lecturer

Specialist Musculoskeletal Physiotherapist

Tim is a consultant physiotherapist who works part time in clinical practice with a focus on the management of complex and chronic injuries and pain disorders. He is involved in the ongoing care of patients as well as providing second opinions on more complicated cases. Tim is also a senior lecturer at Curtin University where he is involved in clinical teaching and research. He has completed a PhD in the area of low back pain and has a special interest in the translation of logical reasoning into clinical practice.

### CONTACT DETAILS:

Curtin University

School of Physiotherapy and Exercise Science

Mobile: 0419926235

Email: [T.Mitchell2@curtin.edu.au](mailto:T.Mitchell2@curtin.edu.au), [Tim.Mitchell@painoptions.com.au](mailto:Tim.Mitchell@painoptions.com.au)

## Dr Darren Beales, PhD

Senior Research Fellow

Specialist Musculoskeletal Physiotherapist

Darren is a consultant physiotherapist in the private, third-party and public domains. He is an Australian National Health and Medical Research Council Research Fellow at Curtin University and Specialist Musculoskeletal Physiotherapist. His research interests include improving understanding of the biopsychosocial nature of pain disorders from a lifespan perspective, and facilitating integration of this knowledge into clinical practice and public policy. He is particularly interested in increasing understanding and outcomes in the workers compensation arena by engaging all stakeholders in the return to work and rehabilitation process.

### CONTACT DETAILS:

Curtin University

School of Physiotherapy and Exercise Science

Mobile: 0418955650

Email: [D.Beales@curtin.edu.au](mailto:D.Beales@curtin.edu.au), [Darren.Beales@painoptions.com.au](mailto:Darren.Beales@painoptions.com.au)

# CONTENTS

<b>TEAM .....</b>	<b>4</b>
<b>SUGGESTED REPORT REFERENCE .....</b>	<b>4</b>
<b>ACKNOWLEDGEMENTS .....</b>	<b>4</b>
<b>EXECUTIVE SUMMARY.....</b>	<b>5</b>
<b>BACKGROUND .....</b>	<b>6</b>
<b>PROJECT AIMS.....</b>	<b>7</b>
<b>METHODOLOGY.....</b>	<b>7</b>
<b>1. DEMOGRAPHICS OF THE RESPONDENTS.....</b>	<b>8</b>
INTERPRETATION- CLINICAL FRAMEWORK FAMILIARITY .....	9
<b>3. FORMAL RISK ASSESSMENT .....</b>	<b>10</b>
INTERPRETATION- FORMAL RISK ASSESSMENT .....	10
<b>4. FORMAL OUTCOME MEASURES .....</b>	<b>12</b>
INTERPRETATION- FORMAL OUTCOME MEASURES.....	12
<b>5. ARTICULATED 'RETURN TO WORK' GOAL .....</b>	<b>14</b>
INTERPRETATION- ARTICULATED 'RETURN TO WORK' GOALS .....	14
<b>6. BARRIERS TO RETURN TO WORK.....</b>	<b>15</b>
INTERPRETATION- BARRIERS TO RETURN TO WORK .....	15
<b>7. EMPOWERING RETURN TO WORK .....</b>	<b>16</b>
INTERPRETATION- EMPOWERING RETURN TO WORK.....	16
<b>8. CASE VIGNETTE.....</b>	<b>17</b>
INTERPRETATION- PUSH THROUGH PAIN .....	18
INTERPRETATION- INCREASE WORK DESPITE PAIN.....	20
INTERPRETATION- NEED FOR PSYCHOLOGICAL MANAGEMENT.....	22
INTERPRETATION- FEAR OF PAIN JUSTIFIABLE .....	24
INTERPRETATION- FEAR OF DAMAGE JUSTIFIABLE.....	26
<b>RECOMMENDATIONS/FUTURE DIRECTIONS.....</b>	<b>28</b>

## Team

Dr Tim Mitchell and Dr Darren Beales were the primary researchers, responsible for all aspects of the project including conception, data collection, data analysis and writing the report.

Leanne Fretwell (WorkCover WA) and James Hay (QBE Insurance) provided input across all stages in collaboration with the primary researchers.

## Suggested Report Reference

Mitchell T, Fretwell L, Hay J and Beales D. 2015. Knowledge and Use of The 'Clinical Framework For the Delivery of Health Services' in Western Australia: Summary report of a survey of Workers' Compensation stakeholders. Curtin University.

## Acknowledgements

Funding for the project was provided by:



Dr Darren Beales was supported by the:



## Executive Summary

The *Clinical Framework for the Delivery of Health Services* (Clinical Framework) provides guiding principles for the management of injured workers based on contemporary evidence.

As part of an “Injured Worker Symposium” hosted by Curtin University in March this year, 161 stakeholders from a variety of roles, who deal with injured workers in the Western Australian Workers’ Compensation sector, completed an online questionnaire. This questionnaire collected stakeholder perspectives regarding the Clinical Framework, barriers and enablers for timely recovery of injured workers, and understanding of the biopsychosocial management of workers with musculoskeletal pain disorders.

This study found that 43% of respondents were ‘not familiar’ with the Clinical Framework. Another 32% were only ‘somewhat familiar’. This suggests that further work is required to educate stakeholders on the existence and utility of the Clinical Framework.

There was strong agreement among the different stakeholder groups regarding the key importance of communication between stakeholders and the employer-employee relationship to the recovery of injured workers.

While this is a preliminary survey and the results need to be interpreted with some caution, the findings of the survey support that further stakeholder education is required in a number of areas related to the Clinical Framework.

This document provides a summary and interpretation of the survey results and recommendations for further research and education, based on the findings of the study.

## Background

The *Clinical Framework for the Delivery of Health Services* (Clinical Framework)<sup>1</sup> is an evidence-based guide designed to support healthcare practitioners delivering services to people with compensable injuries. Developed by the Transport Accident Commission (TAC) and WorkSafe Victoria, this framework reflects contemporary research and has been widely endorsed by Australian workers' compensation jurisdictions, as well as peak health associations.

The Clinical Framework outlines five principles that are shown to deliver optimal recovery and return to work outcomes for injured workers. The principles are:

1. Measure and demonstrate the effectiveness of treatment.
2. Adopt a biopsychosocial approach.
3. Empower the injured person to manage their injury.
4. Implement goals focused on optimising function, participation and return to work.
5. Base treatment on best available research evidence.

WorkCover WA endorses the use of the Clinical Framework by medical and allied health practitioners delivering services to injured workers in Western Australia (WA).

Since its publication in 2012, it is uncertain if and how the evidence-based principles are being integrated into clinical practice in WA. Further, it is unknown if health practitioners and other industry stakeholders have a sound understanding of the barriers and drivers supporting return to work. Knowledge in these areas will assist in the development of future evidence-informed injury management initiatives proposed to support health care practitioners in the scheme.

---

<sup>1</sup> <http://www.worksafe.vic.gov.au/forms-and-publications/forms-and-publications/clinical-framework-for-the-delivery-of-health-services>

## Project Aims

PRIMARY AIM: The primary aim of this project was to survey a sample of health care practitioners and other workers' compensation stakeholders to better understand:

- Current awareness and utilisation of the Clinical Framework.
- Perceptions regarding the most influential barriers and enablers to recovery and return to work for injured workers in WA.

SECONDARY AIM: A secondary aim was to explore contemporary issues in the biopsychosocial presentation of injured workers (as per the Principle Two of the Clinical Framework), by exploring participants' opinions in relation to a brief case vignette.

## Methodology

An anonymous online survey (Qualtrics Online Questionnaire Hosting) was administered at a symposium hosted by Curtin University on the 7<sup>th</sup> March 2015. The symposium, titled "Multidisciplinary Management of Injured Workers with Complex Musculoskeletal Disorders", was fully subscribed with 190 attendees.

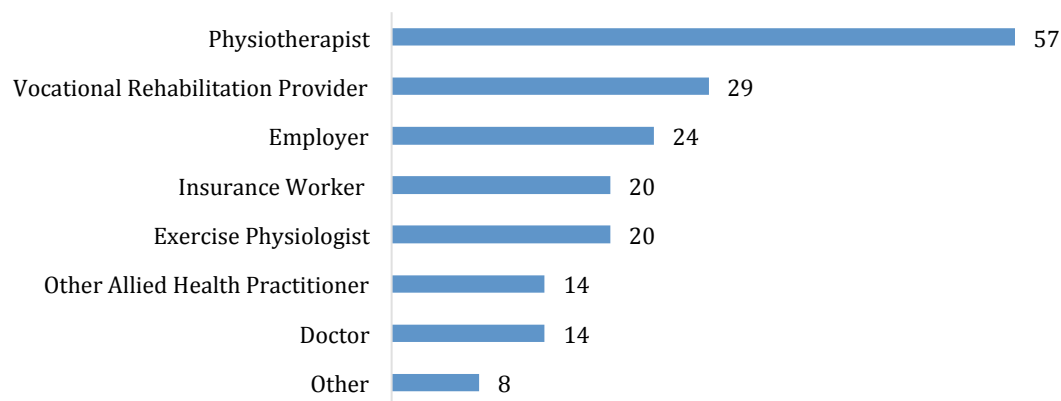
Ethics approval for the project was granted by Curtin University Human Research Ethics Committee (Approval Number RDHS-24-15). All respondents provided consent by voluntarily completing the anonymous survey.

Data was analysed using a combination of Qualtrics Online Questionnaire Hosting inbuilt statistical analysis features, and SPSS statistical package and STATA statistical package.

## 1. Demographics of the Respondents

- 186 people participated in the online survey and 161 completed all questions.
- 67% were female.
- The average years of experience in the workers' compensation arena was 9.2 years (SD 8.8 years; Range 0 to 45 years).

### Breakdown of respondents by profession



### ***Interpretation - demographics***

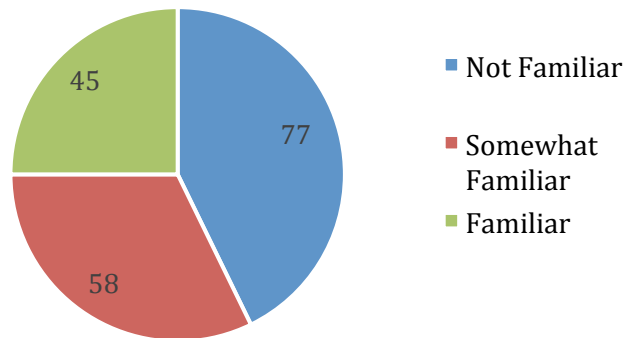
- 245 individuals were invited to complete the survey – comprising the 190 attendees of the symposium plus 55 individuals who expressed interest in attending, but were placed on a waiting list.
- This equates to a response rate of 76% (186) of those who commenced the survey and 66% (161) who completed all questions. The demographics of those who did not complete the survey are not known.
- The sample surveyed had strong representation from physiotherapists (57), vocational rehabilitation providers (29), employers (24), insurance workers (20) and exercise physiologists (20). When considering health care practitioners involved in clinical care of injured workers as one group, they represented 56% (n=105) of the sample.
- On average, the sample had significant experience in the workers' compensation sector (mean 9.2 ± 8.8 years).



## 2. Clinical Framework Familiarity

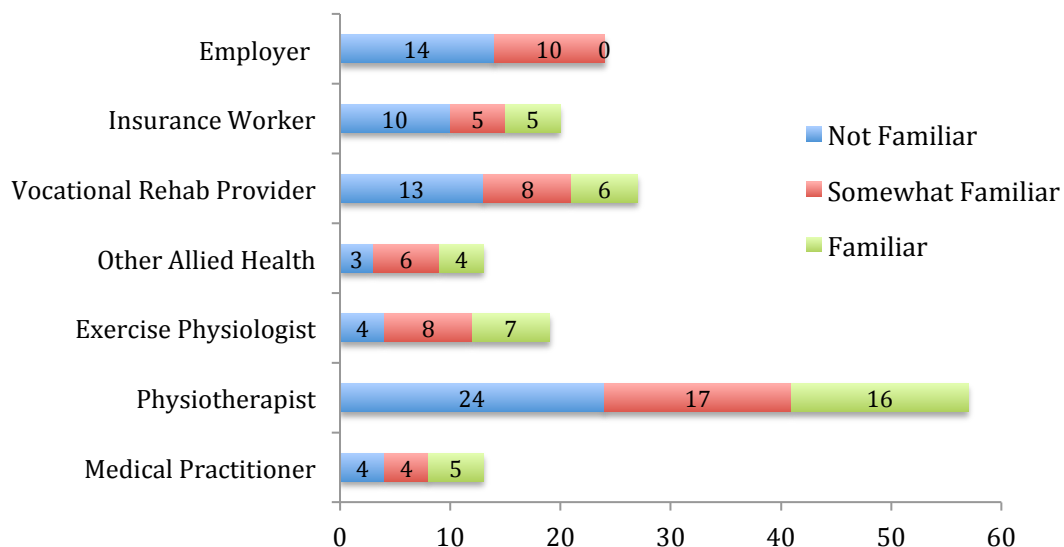
### 2.1 How familiar are you with the 'Clinical Framework for the Delivery of Health Services' endorsed by WorkCover WA?

(Numbers = number of participants with each response)



### 2.2 Familiarity by Profession

( $\chi^2 = 20.1$ , Degrees of Freedom=14,  $p=.13$ )

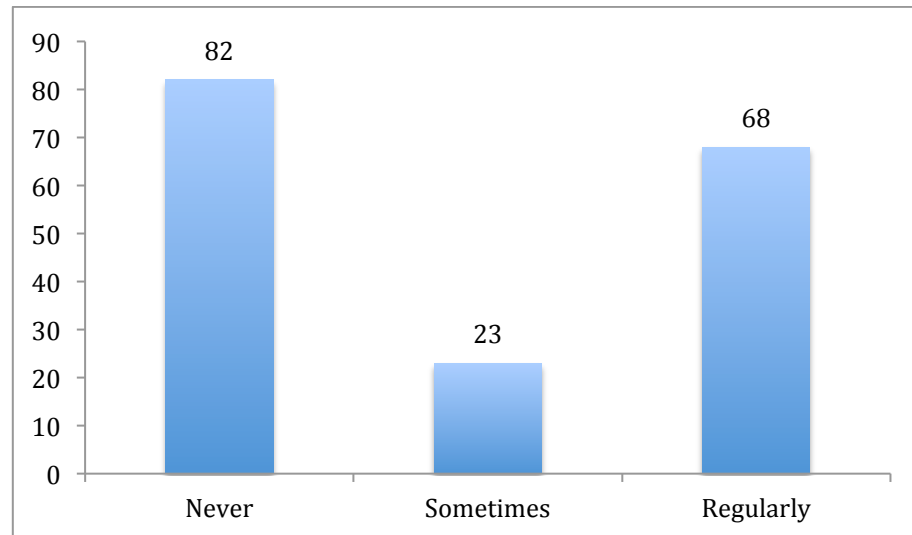


### **Interpretation- Clinical Framework Familiarity**

- A significant proportion of respondents (43%) were not familiar with the Clinical Framework at all and a further 32% were only somewhat familiar with the framework.
- There was no significant difference in familiarity across professions, however, the widespread lack of familiarity with the Clinical Framework among the direct clinical care practitioners surveyed suggests further work is required to increase stakeholder awareness of and engagement with the Clinical Framework.

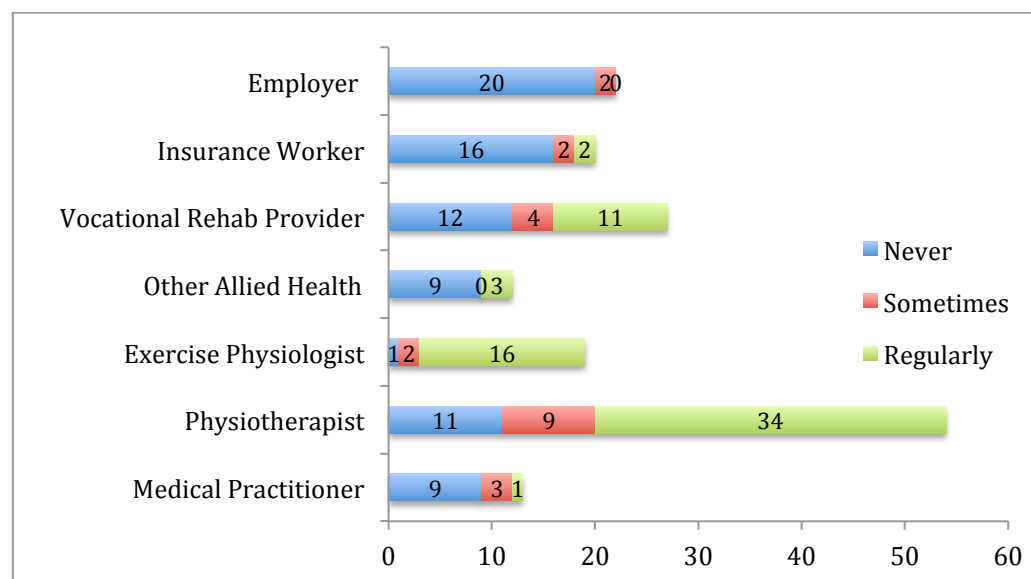
### 3. Formal Risk Assessment

3.1 How often do you use formal risk assessment/screening questionnaires (eg Orebro questionnaire) in your initial interaction with injured workers?



#### 3.2 Screening Tool Use by Profession

( $\chi^2 = 71.3$ , Degrees of Freedom=14,  $p < .001$ )



#### **Interpretation- Formal Risk Assessment**

- Of the 173 respondents, only 68 (39%) regularly used formal screening questionnaires with injured workers on their initial interaction.
- A greater proportion of exercise physiologists (84%) and physiotherapists (63%) regularly used formal screening questionnaires compared with other health care practitioners [medical (7%) and other allied health (25%)] and non-health care stakeholders.

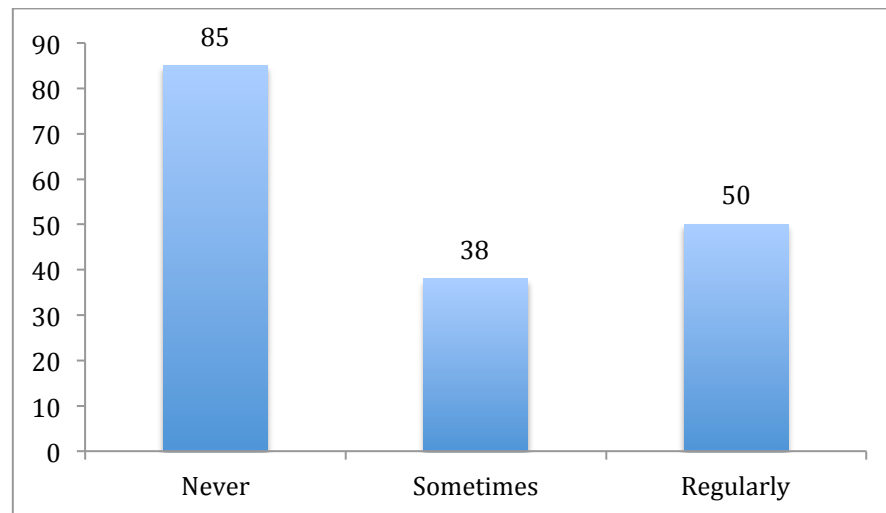
- While moderate utility of formal screening questionnaires by stakeholders is a positive finding, whether this translates into more evidence-informed clinical decisions or case management practice is not known. For example, using validated screening tools has been shown in previous research to assist practitioners to identify workers at higher risk of prolonged time off work<sup>2</sup>. However, it is unclear in the WA Workers' Compensation setting if use of these screening tools translates into different management approaches for High Risk v Low Risk workers, as identified by screening tools (Refer also to Principle Two of The Framework). The findings outlined in Section 8 of this report suggest that screening tools alone do not translate to evidence-informed practice. This is an area for potential research.

---

<sup>2</sup> Linton SJ, Boersma K. Early identification of patients at risk of developing a persistent back problem: the predictive validity of the Orebro Musculoskeletal Pain Questionnaire. Clin J Pain. 2003;19:80-6.

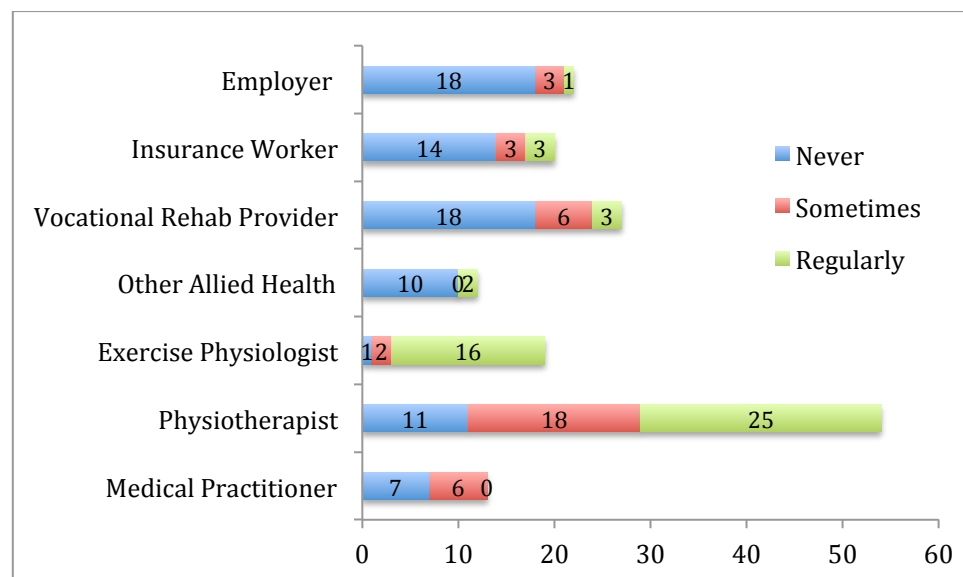
## 4. Formal Outcome Measures

4.1 How often do you use formal outcome measures (questionnaires with accepted reliability, validity and sensitivity to change) when reporting the outcomes of management for injured workers?



### 4.2 Outcome Measure Use by Profession

( $\chi^2=84.4$ , Degrees of Freedom=14,  $p<.001$ )



### Interpretation- Formal Outcome Measures

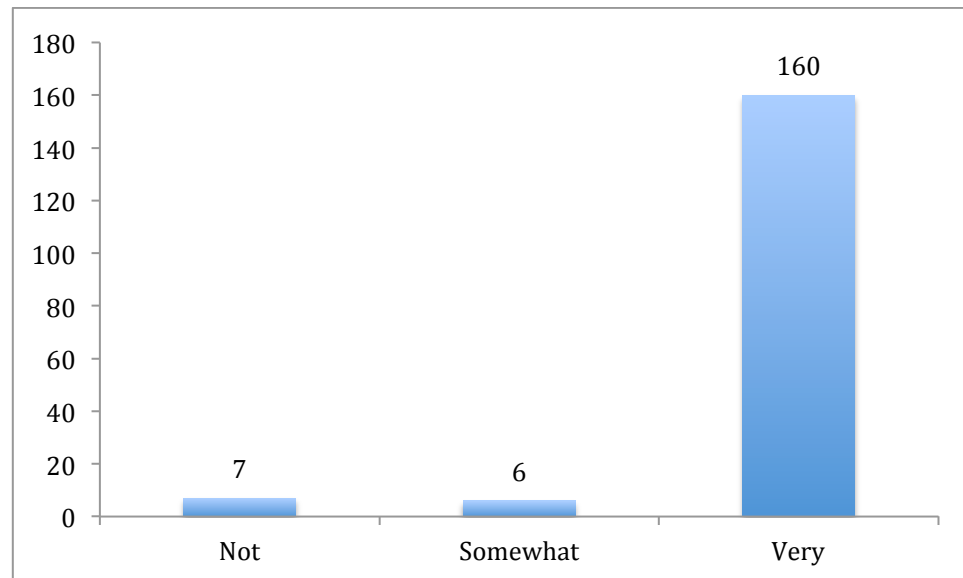
- Only 31% of all respondents (and 44% of practitioners involved in delivery of health services) regularly use formal outcome measures to report the outcome of management for injured workers.
- 84% of exercise physiologists and 46% of physiotherapists regularly use formal outcome measures. This possibly reflects the reporting and

funding approval processes recommended by WorkCover and required as part of all funding approvals via the Treatment Management Plan system for ongoing funding approval of 'reasonable treatment'. Overall compliance with the Treatment Management Plan system is not known though. This is a potential area for additional research.

- The Treatment Management Plan is a formalised way of communicating Principle One of the Clinical Framework, that 'informs and justifies decisions to continue, change or cease treatment, or refer the injured person to another healthcare professional' (p. 3, Clinical Framework document). The Treatment Management Plan is also intended to assist the practitioner to integrate measures of changes in symptoms and function with Return To Work.
- It is unknown whether the current selection of formal outcome measures by stakeholders are appropriate for the individual worker's clinical presentation, or if the use of such outcome measures is just a process of "ticking the box" regarding ongoing Treatment Management Plan funding approval requirements. This is an area for further research.
- The 'Injury Management Plan' incorporated in the new WorkCover WA Certificates of Capacity also encourage GPs/Medical Practitioners to demonstrate Principle One of the Clinical Framework.

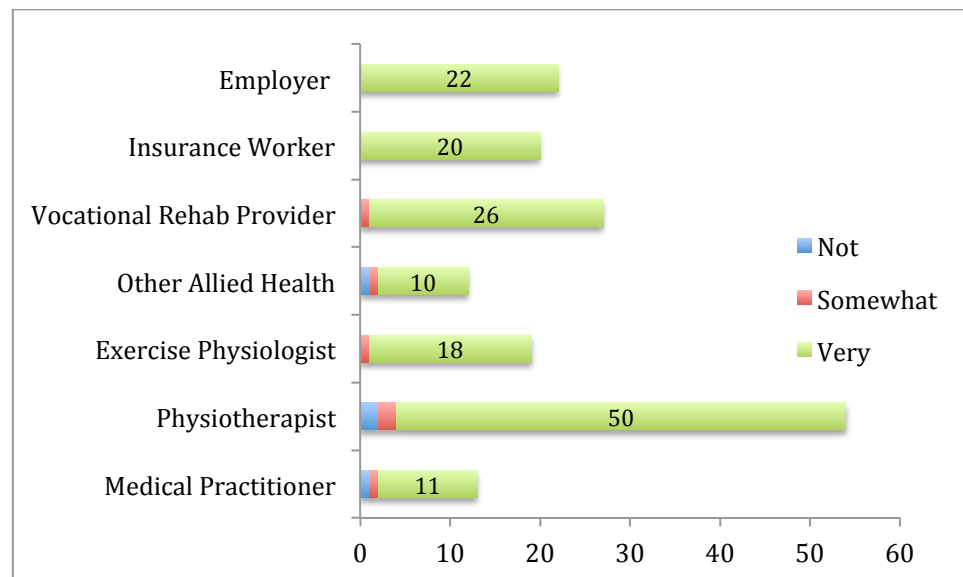
## 5. Articulated 'Return to Work' Goal

5.1 How important do you rate including "return to work" as a specific articulated goal for injured workers?



### 5.2 Articulated 'Return to Work' Goal by Profession

( $\chi^2=40.9$ , Degrees of Freedom=14,  $p<.001$ )



### ***Interpretation- Articulated 'Return to Work' Goals***

- Including "return to work" as a specific articulated goal for injured workers is a broadly accepted practice, with 92% of all respondents reporting that this was considered important.
- Principle Four and page 14 of the Clinical Framework support the importance of this practice.

## 6. Barriers to Return to Work

6.1 Select what you believe are the three most significant barriers facing injured workers when returning to work.

	n	(%)
Psychological distress	104	(65)
Breakdown between Employer/Employee	94	(58.8)
Pain	92	(57.5)
Lack of suitable duties	66	(41.2)
Lack of worker motivation	45	(28.1)
Timely access to appropriate medical services	39	(24.4)
Pathology	15	(9.4)
High fear avoidance	4	(2.5)
Poor early medical management	4	(2.5)
Worker other agenda/secondary gain	3	(2)

### ***Interpretation- Barriers to Return to Work***

- Psychological distress, Breakdown between Employer/Employee and Pain were the most commonly identified barriers to injured workers returning to work. This result is consistent with Principle Two of the Clinical Framework.
- Lack of Suitable Duties was another commonly identified barrier, which when combined with Breakdown between Employer/Employee, supports that work-related factors are very strongly represented as a major barrier to injured workers returning to work. However, it is important to consider that these work-related barriers may be linked with other issues beyond direct workplace issues, such as health care practitioner beliefs and behaviours, injured worker beliefs, other stakeholder beliefs, general communication issues between stakeholders, and non-work related issues for the injured worker.

## 7. Empowering Return to Work

7.1 Select what you believe are the three most significant factors that can be used to empower the injured workers in their recovery.

	n	(%)
Supportive employer	129	(80.6)
Worker motivation	78	(48.8)
Appropriate light duties	69	(43.1)
Accurate early diagnosis	55	(34.4)
Early GP case conference	40	(31.2)
Worker resilience	42	(26.3)
Early Vocation Rehabilitation referral	31	(19.4)
Early investigations/scans	8	(5)
Appropriate early planning	5	(3.1)
Appropriate early education	5	(3.1)
Early multi-disciplinary management	3	(1.9)
Early active exercise	3	(1.9)

### ***Interpretation- Empowering Return to Work***

- A Supportive Employer was selected by 81% of respondents as a significant factor that can empower recovery for injured workers.
- Other commonly identified empowering factors were Worker Motivation, Appropriate Light Duties, Accurate Early Diagnosis and Early GP Case Conference.
- Again, work-related factors are very strongly represented as a major factor influencing injured workers returning to work, but in this instance as a positive enabler.
- Worker Motivation is supported by Principle Three of the Clinical Framework, as it relates to empowering the injured person towards self-management. It is likely that the relationship between the Employer/Employee would be strongly linked worker motivation, which is another area for targeted education and also potential research into the effect of such education.



## 8. Case Vignette

The following brief case history was provided in the survey and was accompanied by some questions related to the case. This is a typical presentation of a worker with 'non-specific' spinal pain (no concerning pathology or damage) who would be at high risk of developing into a long-term claim if not managed using evidence-informed care early in their injury.

*"An injured worker has non-specific spinal pain (no significant MRI findings) that presents as being dominantly non-mechanical. They have high pain sensitivity; allodynia with light touch, hyperalgesia with sharp and cold, pain flare-up with light physical activity, minimal effective strategies for pain relief."*

The Results in 8.1 to 8.6 below outline stakeholder responses to questions regarding appropriate pain management, work duties and psychological management of this typical case. Literature supports that beliefs of health care practitioners strongly influences the case management/clinical care delivered by the health care practitioner<sup>3</sup>. Put simply, if the beliefs of workers' compensation stakeholders are not evidence-informed (Principle Five of the Clinical Framework), it is likely this will translate to sub-optimal clinical and case management decisions for the injured worker. These questions explored this concept in the respondents.

*This same worker displays now displays classic fear avoidance behaviours.*

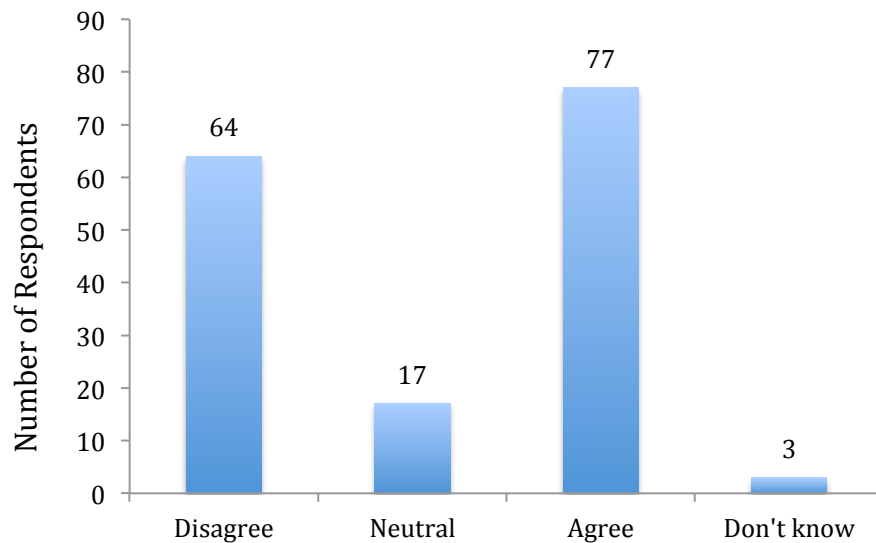
The Results in 8.7 to 8.10 below outline stakeholder responses to questions regarding "fear avoidance". Fear avoidance is strongly linked to increased levels of pain and disability and also poor outcomes following injury. Literature supports that fear avoidance beliefs of patients are strongly influenced by the beliefs of health care practitioners and significant others in contact with the patient<sup>4</sup>. Put simply, if the beliefs of workers' compensation stakeholders are not evidence informed (Principle Five of the Clinical Framework), it is likely this will translate to unhelpful increased fear avoidance and therefore poorer outcome for injured workers. These questions explored this concept in the respondents.

---

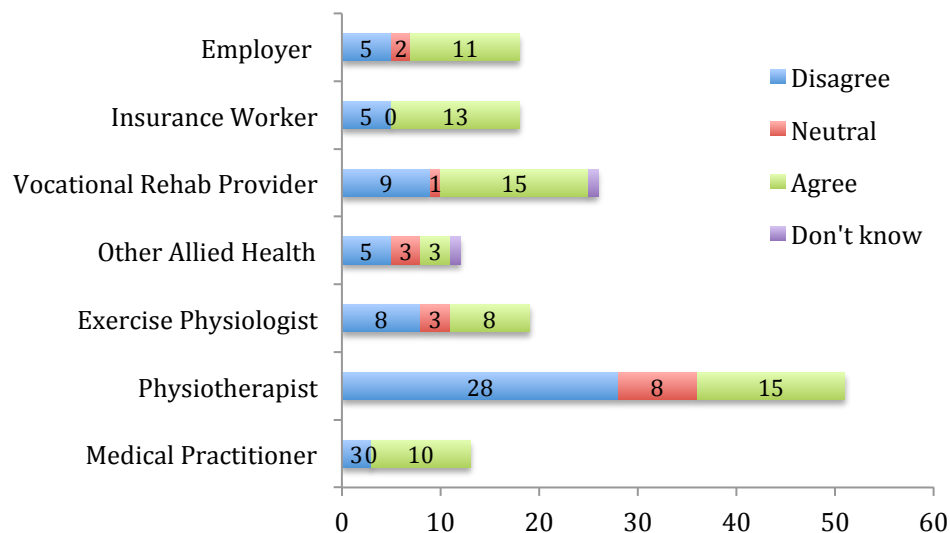
<sup>3</sup> Darlow B, Fullen BM, Dean S, Hurley DA, Baxter GD, Dowell A. The association between health care professional attitudes and beliefs and the attitudes and beliefs, clinical management, and outcomes of patients with low back pain: A systematic review. *Eur J Pain*. 2012;16:3-17.

<sup>4</sup> Werti MM, Rasmussen-Barr E, Weiser S, Bachmann LM, Brunner F. The role of fear avoidance beliefs as a prognostic factor for outcome in patients with nonspecific low back pain: a systematic review. *Spine J*. 2014;14:816-36.

### 8.1 The worker needs to push through their pain to increase their physical capacity.



### 8.2 Push Through Pain by Profession ( $\chi^2=42.3$ , Degrees of Freedom=21, $p=.004$ )



### ***Interpretation- Push Through Pain***

- There was a mix of opinions regarding whether injured workers should push through their pain to increase their physical capacity.
- Based on the brief case vignette provided, it would be reasonable to expect that efforts to increase capacity by “pushing through their pain” would vary

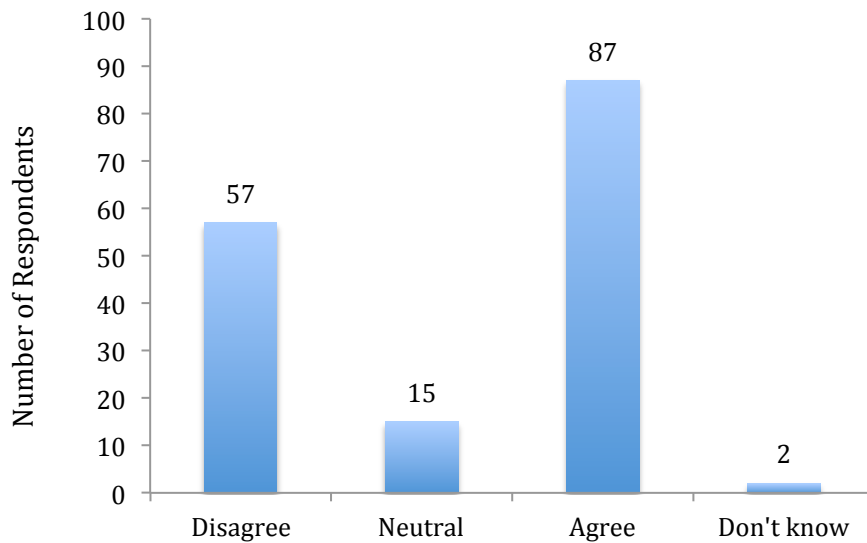
likely result in significant symptom increase and possibly a negative outcome for the worker<sup>5</sup>.

- The professions who most strongly favoured “pushing through their pain” included Medical Practitioners (77%), Insurance Workers (72%), Employers (61%) and Vocational Rehabilitation Providers (58%).
- It is possible that there was some misunderstanding with this question. That is, it is commonplace for practitioners to expect that living and working with some pain (that is, persistent pain) is reasonable. The term ‘push through their pain to increase work capacity’ could have been misinterpreted. Or alternatively, the responses to this question may highlight the confusion among stakeholders regarding appropriate management for workers with persistent pain disorders.
- If the finding that a large number of respondents (48%) agreed with “pushing through their pain” is accurate, education across stakeholders regarding evidence-informed (Principle Five of the Clinical Framework) pain management strategies for individuals with non-mechanical persistent pain should be a priority.

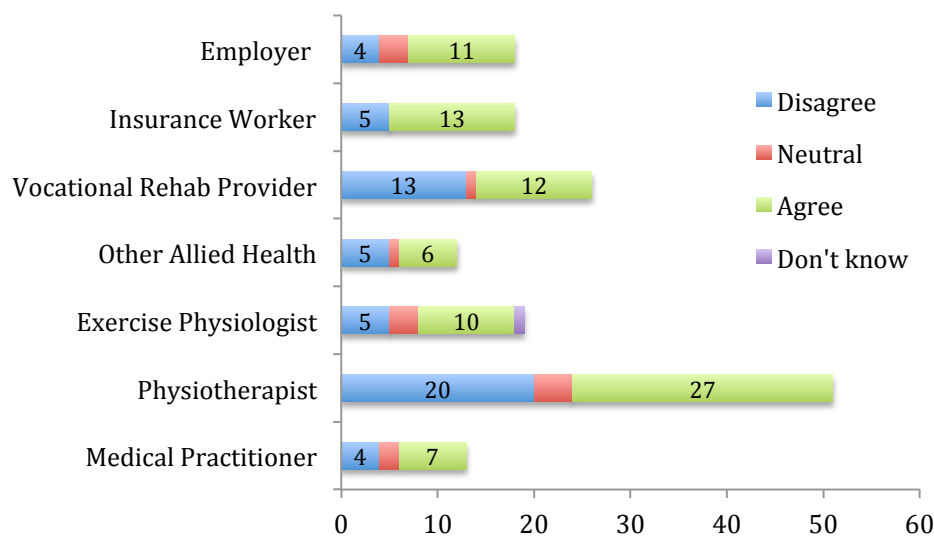
---

<sup>5</sup> Daenen L, Varkey E, Kellmann M, Nijs J. Exercise, not to Exercise or how to Exercise in Patients with Chronic Pain? Applying Science to Practice. Clin J Pain. 2015; In Press.

### 8.3 Return to work programs to increase work capacity should be gradually progressed/advanced despite any increases in pain.



### 8.4 Increase Return to Work Despite Pain by Profession ( $\chi^2 = 34.4$ , Degrees of Freedom=21, $p=.032$ )

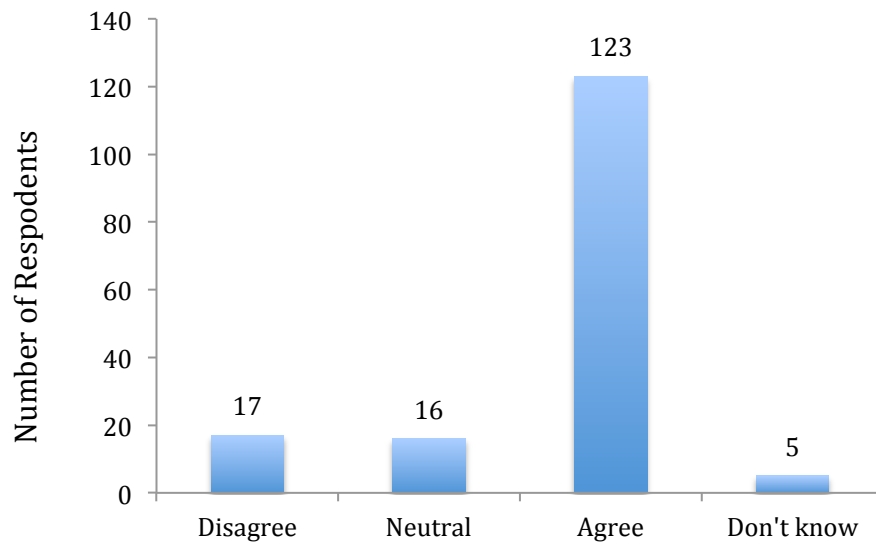


#### **Interpretation- Increase Work Despite Pain**

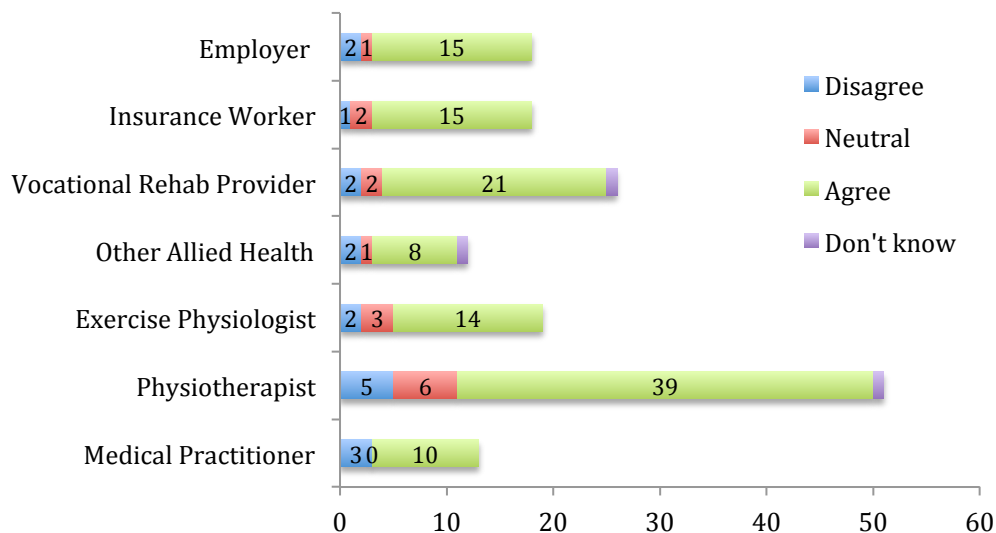
- There was a mix of opinions, but 54% of respondents reported work capacity should be gradually progressed/advanced despite any increases in pain.
- Based on the brief case vignette provided, it would be reasonable to expect that increasing work capacity by “pushing through their pain” would very likely result in significant symptom increase and possibly a negative outcome for the worker.

- Around half of respondents from each profession favoured increasing work capacity despite any increases in pain, but strongest agreement was from Insurance Workers (72%).
- Similar to the previous question, the responses support education across stakeholders regarding evidence informed pain management strategies for individuals with non-mechanical pain should be considered.

8.5 This worker will need formal psychological management to help get over their pain.



8.6 Needs Formal Psychological Management Pain by Profession  
( $\chi^2 = 40.6$ , Degrees of Freedom=21,  $p = .006$ )



### ***Interpretation- Need For Psychological Management***

- 76% of respondents agreed that the worker would need formal psychological management to help get over their pain. This is despite there being no mention of negative psychological factors within the case study.
- While increased psychological distress (particularly depression) is a strong predictor of increased pain and disability, not every person with a persistent

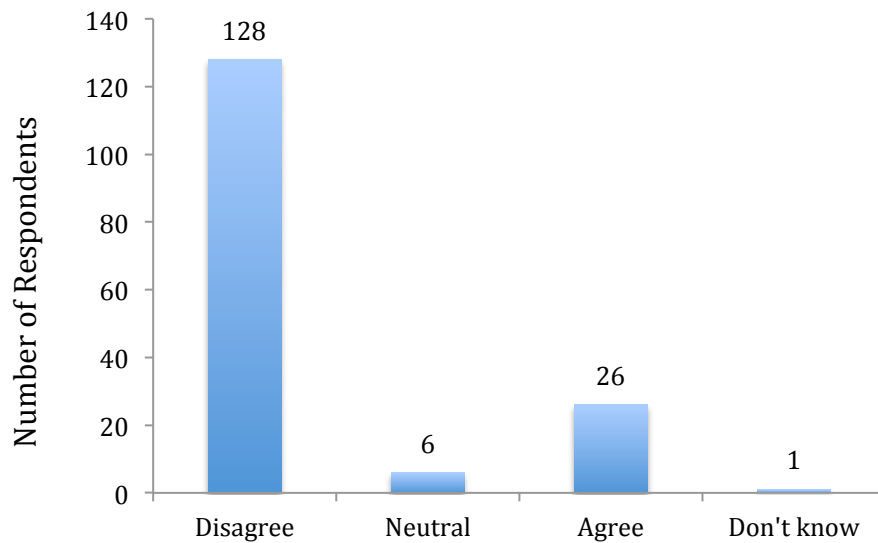
pain problem will have psychological distress at a level that will require formal psychological management<sup>6</sup>.

- This question relates to stakeholders' understanding of the role of psychological distress in non-specific spinal pain. The result suggests that in general, stakeholders recognize the importance of psychological distress as a risk factor, but not necessarily that the contribution of psychological factors needs to be considered for each injured worker on an individual basis<sup>5</sup>.
- Evidence-informed practice supports the use of validated screening tools to identify the presence of clinically significant psychological distress (Principles Two and Five of the Clinical Framework). These results support further education of stakeholders on practical application of these aspects of the Clinical Framework.

---

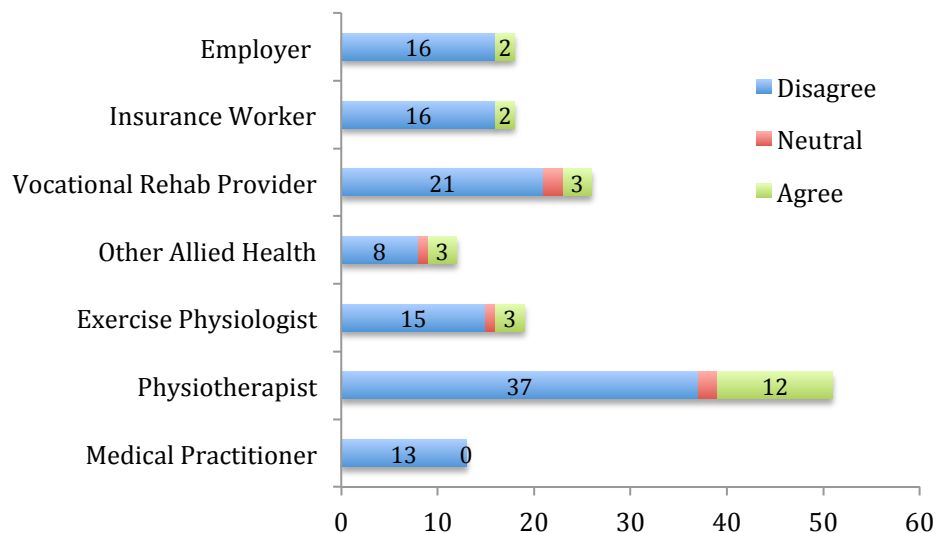
<sup>6</sup> Rabey M, Beales D, Slater H, O'Sullivan P. Multidimensional pain profiles in four cases of chronic non-specific axial low back pain: An examination of the limitations of contemporary classification systems. *Man Ther.* 2015;20:138-47.

**8.7 Fear of increasing pain** is a valid reason for this injured worker to avoid activity.



#### 8.8 Fear of Pain by Profession

( $\chi^2 = 50.7$ , Degrees of Freedom=21,  $p < .001$ )



#### **Interpretation- Fear of Pain Justifiable**

- 79% of all respondents **disagreed** that **fear of increasing pain** is a valid reason for this injured worker to avoid activity.
- 100% of Medical practitioners disagreed with this statement.



- The response of the majority of respondents is **not consistent** with contemporary literature<sup>7</sup>. Fear of **increasing pain** is regarded as a valid reason for avoiding specific activities – if the individual's experience is that their pain does increase when performing those specific activities. An example might be fear of repeated bending, when repeated bending has been a cause of significant symptom flare-ups in the past.
- These results support the need for stakeholder education in this area.

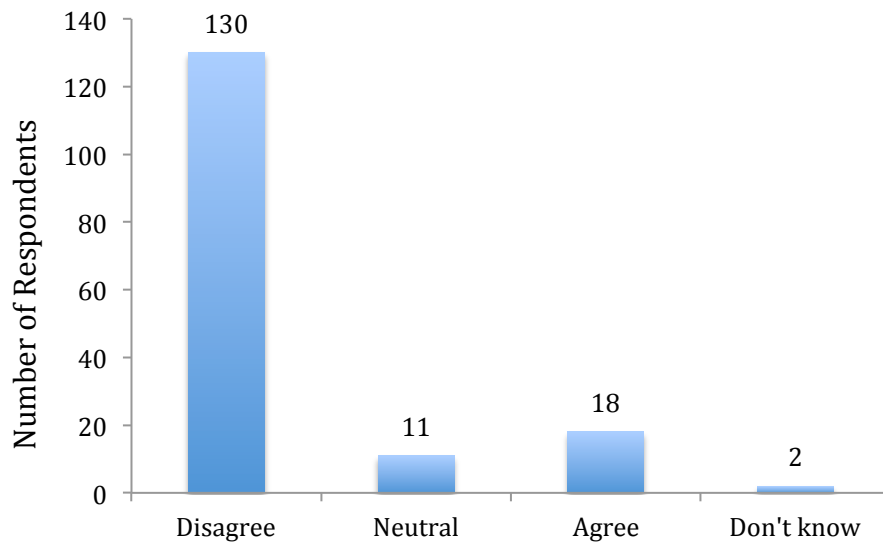
---

<sup>7</sup> Werti MM, Rasmussen-Barr E, Weiser S, Bachmann LM, Brunner F. The role of fear avoidance beliefs as a prognostic factor for outcome in patients with nonspecific low back pain: a systematic review. *Spine J*. 2014;14:816-36.

Bunzli S, Smith A, Watkins R, Schütze R, O'Sullivan P. What do people who score highly on the Tampa Scale of Kinesiophobia really believe? A mixed methods investigation in people with chronic non specific low back pain. *Clin J Pain*. 2014.

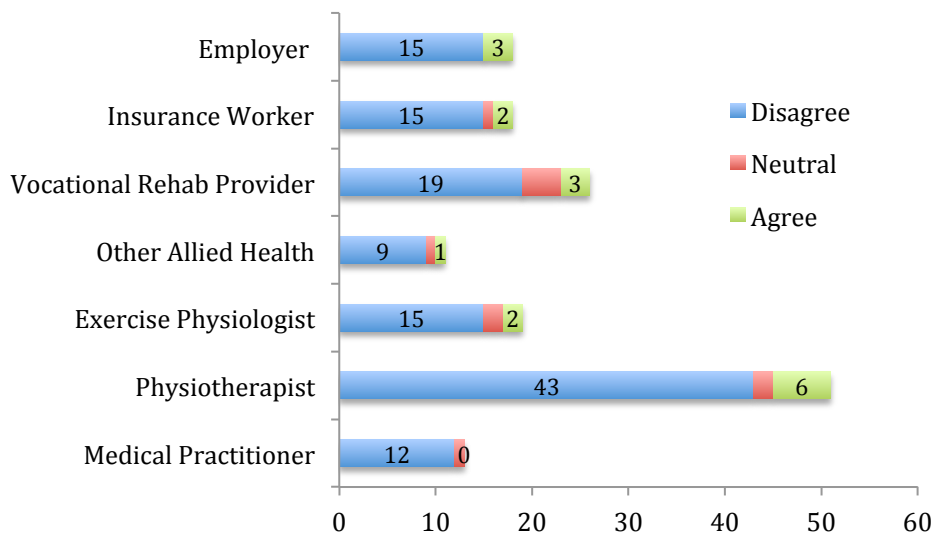
Vlaeyen JW, Linton SJ. Fear-avoidance model of chronic musculoskeletal pain: 12 years on. *Pain*. 2012;153:1144-7.

**8.9 Fear that pain means they are damaging their spine** is a valid reason for this injured worker to avoid activity.



#### 8.10 Fear of Pain by Profession

( $\chi^2 = 34.0$ , Degrees of Freedom=21,  $p=.036$ )



#### **Interpretation- Fear of Damage Justifiable**

- 81% of all respondents **disagreed** that **fear that pain means they are damaging their spine** is a valid reason for this injured worker to avoid activity.
- Fear or avoidance of an activity due to fear of **damaging their spine** is not regarded as a valid reason for avoiding specific activities – as there is no evidence that the individual is at risk of damaging their spine. An example

might be fear of repeated bending, due to an unfounded fear that this will result in damage to a disc.

- While the response of the majority of respondents is **consistent** with contemporary literature, the converse finding in 8.7 and 8.8 suggest that stakeholders generally perceive fear-avoidance as a negative psychological factor, perhaps without understanding the different implications of **fear of pain** versus **fear of damage**<sup>8</sup>.

---

<sup>8</sup> Bunzli S, Smith A, Watkins R, Schütze R, O'Sullivan P. What do people who score highly on the Tampa Scale of Kinesiophobia really believe? A mixed methods investigation in people with chronic non specific low back pain. Clin J Pain. 2014.

## Recommendations/Future Directions

It again needs to be emphasized that this was a preliminary study. The response rate of participants from the symposium was high and the 161 respondents represent a range of different stakeholder groups. However, the questions developed for the study have not been validated in previous research and the results need to be interpreted with some caution. Based on the authors' interpretation of the survey results, the some recommendations have been provided for consideration.

1. Further promotion of the 'Clinical Framework' is recommended.
  - a. As a method of educating stakeholders in evidence-informed injury management principles.
  - b. To improve the quality of clinical treatment provided to injured workers, which would likely translate into improved outcomes and reduced claim costs for injured workers.
  - c. To improve the literacy of officers making claims management decisions.
  - d. To improve the communication of injury management parties, especially to the injured worker.
2. Promote or support education to better inform a number of widely held beliefs held amongst a range of workers' compensation stakeholders that are not consistent with contemporary literature.
3. Promote initiatives that develop skills in overcoming work-related barriers to recovery (employer/employee relationships) and optimise work-related enablers (identifying suitable duties) to all stakeholders, particularly employers.
4. Further research possibilities include:
  - a. Larger sample of different stakeholders survey
  - b. Survey of clinical care stakeholders – regarding whether use of validated screening tools and outcome measures are strategies that result in increased delivery of evidence-informed delivery of health services for injured workers
  - c. An educational intervention with pre- post- intervention assessment to evaluate the effectiveness of stakeholder educational strategies